City of Duluth
2013 Retiree/Survivor Health Plan
Open Enrollment Guide

Benefit Elections for Plan Year
January 1 through December 31, 2013

Deadline for submitting forms:
Monday, November 26, 2012, at 4:30 p.m.

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City of Duluth
Human Resources Office

411 West First Street • Room 313 • Duluth, Minnesota • 55802-1195
218-730-5210 • Fax: 218-730-5906 • www.duluthmn.gov/employment

An Equal Opportunity Employer

November 13, 2012

Re: 2013 Open Enrollment (November 13 through November 26, 2012, 4:30 p.m.)

Dear Retiree/Survivor Health Plan Participant:

We are pleased to provide you with your 2013 Open Enrollment material. Open Enrollment begins Tuesday, November 13, 2012, and ends at 4:30 p.m. on Monday, November 26th. All Benefits Enrollment Forms must be received in the Human Resources Office by the Open Enrollment deadline.

As you know, providing quality health care coverage to all of our employees and retirees is a priority for the City of Duluth, the Duluth Airport Authority (DAA), Duluth Entertainment and Convention Center (DECC), the Housing Redevelopment Authority (HRA), and the Board members of the Duluth Joint Powers Enterprise (JPE) Trust. This commitment to providing quality coverage is balanced by our joint concerns for maintaining costs at a reasonable level. Together we have worked hard to ensure that both of these priorities are met.

Following is a summary of benefit plan changes effective January 1, 2013:

- Health plan premiums are increasing 18%
- Prescription Drug Protocol Management changes – Step Therapy and Prior Authorizations for specialty drugs
- Medicare Supplement Plan offering for Medicare-eligible members
- Special enrollment instructions for January 1, 2013 – please refer to the 2013 Open Enrollment Guide for details

Health Plan Premium Increase

Health plan premiums are increasing 18%. Please note that your responsibility of the premium cost-sharing will remain the same. For example, if your responsibility of the premium is 50%, you will continue to pay 50% of the premium. If you are not required to pay a percentage of the premium, you will not be responsible for any premium payments in the upcoming plan year.

Medicare Supplement Plan Offering

A fully insured HealthPartners Medicare Supplement Plan will be provided to Medicare-eligible members (i.e., members enrolled in Medicare Parts A and B) effective January 1, 2013.

- If you are Medicare-eligible and enrolled in Medicare Parts A and B, HealthPartners will automatically transition you to the Medicare Supplement Plan effective January 1, 2013 – you do not need to do anything. You will receive your new ID card in December.
- HealthPartners will contact plan members who become Medicare-eligible during 2013; it is the member's responsibility to complete the Medicare Supplement Plan enrollment forms and provide HealthPartners with all required documentation. ***Failure to complete the enrollment form and submit documentation to HealthPartners may result in the loss of health care coverage for the member.***
- **The only retiree health plan members permitted to opt out of the Medicare Supplement Plan offering and continue coverage under the current health plan are:**
  1. Retiree health plan members***** with dual coverage (i.e., members covered as a subscriber and a dependent); **or**
  2. Former City of Duluth employees***** who:
     - Belonged to the PERA Basic Plan or PERA Fire and Police Plan **and**
     - Were exempt from paying the mandatory Medicare Tax **and**
     - Ineligible to obtain Medicare Part A through a spouse or former spouse

  ****All retiree health plan members are required to enroll in Medicare Part B upon initial eligibility***

Medicare Part A and Part B

All eligible health plan members must enroll in Medicare Parts A and B when first eligible. Members can sign up during the Medicare Open Enrollment period – January 1 through March 31 each year. For further information regarding eligibility and enrollment, please contact your local Social Security Administration office at (218) 727-1193 (toll-free at 1-800-772-1213) or you can obtain information online at www.ssa.gov. If you have not worked enough quarters to qualify to Medicare Part A, please call the Retiree Transition Hotline at 1-877-635-9314 for further instructions.

IMPORTANT: Special Health Plan Enrollment Process for January 1, 2013

The following steps will be taken with your current retiree health plan coverage:

1. The health plan member who is Medicare-eligible will automatically be moved to the HealthPartners Medicare Supplement Plan. A new ID card for both medical and prescription drug services will be issued in December.
2. Eligible dependents covered by the plan that are not Medicare-eligible will remain on Plan 3A unless otherwise notified.
3. **You must complete and submit your 2013 Benefits Enrollment Form no later than 4:30 p.m. on Monday, November 26, 2012, if you wish to do any of the following:**
   - Add or cancel a dependent's coverage to your Health Plan 3A coverage

Retiree Open Enrollment Meeting

Representatives from HealthPartners and CBIZ will be in attendance during the Retiree Open Enrollment Meeting to answer your questions. Human Resources representatives will also be available to assist with questions or completion of your Benefits Enrollment Form.

Date	Time	Location
Wednesday, November 14th	**12:30 – 2:00 p.m.**	**DECC - Gooseberry Falls Room 3**
***Free Parking will be available*. City Side Convention Center – use Entrance B.** **Stay on the ground floor and follow the posted signs to direct you to the designated location.**		

Open Enrollment Deadline

The Benefits Enrollment Form is due in the Human Resources Office (Room 313, City Hall) no later than 4:30 p.m. on Monday, November 26, 2012, in order to allow Human Resources staff sufficient time to accurately process benefit elections and communicate changes with benefit vendors for the coming year.

I encourage you to please carefully review and consider the information provided in the 2013 Open Enrollment Guide. Should you have questions or would like to request clarification on any of the plan options, our Human Resources representatives are happy to assist you.

Best regards,

K. Hall

Kim Hall, Manager
Human Resources, Healthcare, and Safety

Annual Open Enrollment Period: November 13 - November 26, 2012

During Open Enrollment is your opportunity to change your current health benefits election for the upcoming calendar year.

Two Easy Steps for a Successful Open Enrollment

1. Gather Information

- ***Carefully review the information in your Open Enrollment Guide:***
  - Available benefit plan selections and 2013 monthly health plan premiums

- ***Open Enrollment Meeting***
  - For your convenience, HealthPartners, CBIZ, and Human Resources representatives will be available to assist with Open Enrollment questions (see page 17 for details).

2. Enroll

- ***If you choose to keep your current health coverage without making any changes, no action is necessary.***
- ***If you wish to add or remove dependents from your current coverage, you will need to complete the enclosed Benefits Enrollment Form and submit it to the Human Resources Office no later than 4:30 p.m. on Monday, November 26, 2012.***

Plan Eligibility

Eligible Retirees

The collective bargaining agreements determine eligibility for retiree medical benefits.

Eligible Dependents

Spouse

a.) Legally married opposite gender spouse; or
b.) Legally separated opposite gender spouse.

Dependent Child - birth through age 25 (up to the child's 26th birthday):

a.) An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild or any other child state or federal law requires be treated as a dependent.
b.) A grandchild you claim as an exemption on your Federal income tax return and who is financially dependent upon you.
c.) A child of the subscriber who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).

Key Changes for 2013

Health Plan 3A

- Effective January 1, 2013, health plan premiums will increase 18%. Please note that your responsibility of the health care premium cost-sharing will remain the same. For example, if your responsibility of the premium payment is 50%, you will continue to pay 50% of the premium. However, if you are not required to pay a percentage of the premium, you will not be responsible for any premium payments in the upcoming plan year.
- ***Retiree health plan members who are not Medicare-eligible will remain on Plan 3A***
- HealthPartners has made slight changes to member ID cards and will be issuing new ID cards in December to promote clarity for providers that process your medical claims
- Introducing new prescription drug management protocol – new step therapy categories added and Prior Authorizations required for specialty drugs. Please refer to the ClearScript Summary Plan Description for details.

Medicare Supplement Plan effective January 1, 2013

The Duluth Joint Powers Enterprise (JPE) Trust approved the adoption of a Medicare Supplement Plan administered by HealthPartners for all Medicare-eligible members. The benefits provided under this plan are equal to or better than the benefits under Plan 3A.

Because Medicare recognizes that HealthPartners does a better job of managing the members' health plan, Medicare agrees to pay HealthPartners a capitation amount every month for each enrolled participant. The cost savings of the Coordination of Benefits (COB) and the capitation results in a significant reduction in the premium needed. Under the Medicare Supplement Plan contract, all rates are pooled – no individual group is rated on its own but rather a rate is set (and approved by CMS) for the entire pool/community. The HealthPartners pool is made up of approximately 50,000 contracts, which allows for a very stable pool and risk calculation.

What does this mean for me?

All retiree health plan members who are Medicare-eligible and enrolled in Medicare Parts A and B will be automatically enrolled in the HealthPartners Medicare Supplement Plan (please refer to page 9 for a summary of the benefits). Under this arrangement, members must have both Medicare Parts A and B. Medicare pays primary on all Part A services and HealthPartners pays primary on all Part B and D services. You will receive a notice from HealthPartners that includes important information about the Medicare Supplement Plan. Please review the information carefully. You do not need to do anything to be automatically enrolled. However, you must contact and inform HealthPartners by November 30, 2012, if you do not wish to join (i.e., opt out of) the Medicare Supplement Plan.

When will I receive my new Medicare Supplement Plan ID card?

You will receive your new membership ID card in December. Please note, your new ID card will be used for both medical and prescription drug plan benefits.

What happens if I do not wish to join the Medicare Supplement Plan?

You will no longer be provided retiree medical benefits through the Duluth JPE Trust and your benefits under Plan 3A will be cancelled after December 31, 2012.

What happens if I am not enrolled in Medicare Parts A and/or B?

All Medicare-eligible members are required to be enrolled in Medicare Parts A and B. Please contact the local Social Security Administration office at (218) 727-1193 (toll free at 1-800-772-1213) or you can obtain information online at www.ssa.gov.

The only retiree health plan members permitted to opt out of the Medicare Supplement Plan offering *and* continue coverage under the current health plan are:

1. Retiree health plan members* with dual coverage (i.e., members covered as a subscriber and a dependent); **or**
2. Former City of Duluth employees* who:
   - Belonged to the PERA Basic Plan or PERA Fire and Police Plan **and**
   - Were exempt from paying the mandatory Medicare Tax **and**
   - Ineligible to obtain Medicare Part A through a spouse or former spouse

*All retiree health plan members are required to enroll in Medicare Part B upon initial eligibility

If you meet the above criteria, please contact the City of Duluth's Human Resources Office at (218) 730-5197, (218) 730-5198, or (218) 730-5204, immediately for assistance.

Health Payment Coupons for 2013

- For plan participants who contribute to the cost of retiree medical premiums, Genesis Employee Benefits will mail new payment coupons to participants' homes early December 2012.

Dependent Information

- Federal law requires the reporting of Social Security Numbers (SSNs) to the Centers for Medicare & Medicaid Services (CMS) for covered dependents. Please include the SSNs for all dependents that will be covered under your health plan.

Summaries of Benefits and Coverage

- Understanding your health plan is important. The Summary of Benefits and Coverage (SBC) provides important information about your Duluth JPE Trust Health Plan 3A coverage in a standard format so that you can easily compare benefits to other health plans. The SBC for the health plan will also be available online at www.duluthmn.gov/employment/benefits. Paper copies are available, free of charge, by calling Human Resources at (218) 730-5210. If there are any differences between this Open Enrollment Guide and the SBC publications, the Summary Plan Documents will govern.

2013 Health Plan Premiums
Duluth Joint Powers Enterprise Trust

Retiree Health Plan Premiums for Medicare-eligible* Members		
Two Members	Retiree and one Eligible Dependent: At least one member Medicare-eligible*	**$885.00**
Three or more Members	Retiree and two or more Eligible Dependents: At least one member Medicare-eligible*	**$1,184.00**
***Enrollment in Medicare Parts A and B required**		

Retiree Health Plan Premiums for Retirees 65 and over who are <u>not</u> Medicare-eligible+		
One Member	Retiree without dependents: Retiree is at least 65 and not Medicare-eligible	**$524.00**
Two Members	Retiree with one dependent: Retiree **<u>and</u>** dependent are least 65 and not Medicare-eligible	**$1,022.00**
	Retiree with one dependent: Retiree or dependent is at least 65 and not Medicare-eligible	**$1,143.00**
Three or more Members	Retiree with two or more dependents: Retiree is at least 65 and not Medicare-eligible	**$1,506.00**
+Enrollment in Medicare Part B required upon member's initial eligibility		

- Your retiree medical coverage will be your primary coverage until you become eligible for Medicare or attain age 65, **and** obtain coverage through the Federal Medicare Program. At that time, your primary coverage would be through Medicare, with your secondary coverage through the Duluth Joint Powers Enterprise Trust sponsored Medicare Supplement Plan.

- <u>Note – The percentage level of your share of the health care premium cost is not changing. For example, if you are responsible for 50% of the health care premium, your responsibility of the health care premium continues to be 50%. If your health care premium is fully subsidized, you will not be required to pay any part of the health care premium in 2013.</u>

Duluth Joint Powers Enterprise Trust

HealthPartners Medicare Supplement Plan

Medical and Prescription Drug Plan Overview
Effective January 1, 2013

Deductible and Lifetime / Out-of-Pocket Maximums	
Lifetime Maximum	Unlimited
Annual Deductible (combined for outpatient services for illness and injury)	$250
Annual Out-of-Pocket Maximum (medical only)	$1,250

Benefit / Service within U.S.	HealthPartners Medicare Supplement Plan
Preventive Health Care	
Routine physical, eye and hearing exams	100% coverage, not subject to deductible
Immunizations	100% coverage, not subject to deductible
Hearing	100% coverage, not subject to deductible
Vision	100% coverage, not subject to deductible
Office Visits	
For illness or injury	80% coverage after deductible
Chiropractic care	80% coverage after deductible
Mental health care	80% coverage after deductible
Podiatry	80% coverage after deductible
Inpatient Hospital Care	
For illness or injury	$50 copay, not subject to deductible
Mental health care	$50 copay, not subject to deductible
Chemical health care	$50 copay, not subject to deductible
Skilled nursing facility	100% coverage
Emergency Care	
Emergency room	80% coverage not subject to deductible
Urgently needed care	80% coverage after deductible
Ambulance	80% coverage not subject to deductible
Outpatient Medical Services and Supplies	
Physical / occupational therapy	80% coverage after deductible
Speech / language therapy	80% coverage after deductible
Durable medical equipment	80% coverage not subject to deductible
Prosthetics	80% coverage not subject to deductible
Diabetes self-monitoring training, nutrition therapy	100% coverage
Diabetes supplies	80% coverage not subject to deductible
Diagnostic tests, radiology, lab services	80% coverage not subject to deductible

Benefit / Service within U.S.	HealthPartners Medicare Supplement Plan
Drug Benefit, Retail Summary	
Generic drugs	**$0 copay**
Preferred brand drugs	**$15 copay**
Non-preferred brand drugs	**$30 copay**
Specialty drugs	**$30 copay**

HealthPartners is a health plan with a Medicare contract.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information refer to your Summary of Benefits, Evidence of Coverage, or call Member Services at (952) 883-7979 or 1-800-233-9645. Benefits, formulary, pharmacy network, premiums, and/or copayments may change on January 1, 2014.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- Medicare: 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048
  24 hours a day, 7 days a week
- The Social Security Office: 1-800-772-1213; TTY: 1-800-325-0778.
  Monday through Friday, 7:00 a.m. to 7:00 p.m.
- Or your Medicaid Office.

Duluth Joint Powers Enterprise Trust
Comprehensive Hospital-Medical Benefit Plan 3A
Administered through HealthPartners
Effective January 1, 2013

The following is an overview of your coverage. For exact coverage terms and conditions, consult your plan materials, or call Member Services at (952) 883-5000 or 1-800-883-2177.

Deductible and Lifetime / Out-of-Pocket Maximums		
	In-Network Care from a network provider	**Out-of-Network±** Care from an out-of-network provider
Lifetime Maximum	Unlimited	$2,000,000
Calendar year deductible	$250 per person; $500 per family	
Calendar year medical out-of-pocket maximum	$1,250 per person; $2,500 per family	

Plan Highlights Partial listing of covered services	**In-Network** Care from a network provider (Open Access Network)	**Out-of-Network±** Care from an out-of-network provider
Preventive Health Care		
Routine physical exam*	100%	100%
Routine cancer screening*	100%	100%
Routine eye exam*	100%	100%
Routine hearing exam*	100%	100%
Lab and x-ray services	100%	100%
Immunizations	100%	100%
Prenatal and postnatal care	100%	100%
Well-child care	100%	100%
*One routine physical, cancer screening, eye, and hearing exam per calendar year will be covered under preventive health care. Subsequent physicals, cancer screenings, eye, and hearing exams will be treated as a physician office visit.		
Physician Office Visits		
Illness or injury (including lab and x-ray services, and outpatient surgery)	80% after deductible	80% after deductible
Allergy-related services	80% after deductible	80% after deductible
Physical, occupational & speech therapy	80% after deductible	80% after deductible
Chiropractic care (neuromusculo-skeletal conditions only)	80% after deductible	80% after deductible
Behavioral Health Care (Inpatient and Outpatient Services)		
Mental health care	80% after deductible	80% after deductible
Chemical dependency health care	80% after deductible	80% after deductible
Convenience Care		
Convenience clinics (e.g., Retail/Minute Clinics)	80%	80%
eVisits	80%	80%
Virtuwell – Online care	80%	80%

Plan Highlights Partial listing of covered services	**In-Network** Care from a network provider (Open Access Network)	**Out-of-Network±** Care from an out-of-network provider
Emergency Care		
Urgent Care	80% after deductible	80% after deductible
Emergency care at a hospital Emergency Room	80% after deductible	80% after deductible
Ambulance	80% after deductible	80% after deductible
Hospital Care (Inpatient and Outpatient Services)		
Illness or Injury (including lab and x-ray services, and surgery)	80% after deductible	80% after deductible
Scheduled inpatient and outpatient procedures	80% after deductible	80% after deductible
Outpatient MRI and CT scan	80% after deductible	80% after deductible
Durable Medical Equipment		
Durable medical equipment	80% after deductible	80% after deductible
Prosthetics	80% after deductible	80% after deductible
Medical Supplies	80% after deductible	80% after deductible

Outpatient Prescription Drug Benefits administered through ClearScript

The following is an overview of your prescription drug benefit coverage. For exact coverage terms and conditions, consult your plan materials, call Customer Service at-1-800-546-5677, or visit www.clearscript.org/Duluth.

Tier	**Type of Drug**	**Co-Payment Amount**
Tier One	Generics	$0 co-payment
Tier Two	Preferred Brands	$15 co-payment
Tier Three	Non-Preferred Brands (Specialty Drugs)	30% co-insurance ($30 min/$100 max)

± Members using out-of-network providers may be responsible for filing their own claims and for any charges that exceed the HealthPartners allowed amount. These amounts are not applied to the out-of-pocket maximum. Additionally, out-of-network providers and facilities may not take care of notification requirements. Please refer to your health plan summary document or contact HealthPartners Member Services for a description of charges that are your responsibility. Additionally, you must call CareCheck® at (952) 883-5800 or 1-800-942-4872 to receive maximum benefits when using out-of-network providers for in-patient hospital stays; same-day surgery; new or experimental or reconstructive outpatient technologies or procedures; durable medical equipment or prosthetics costing more than $3,000; home health services after your visits exceed 30; and skilled nursing facility stays. HealthPartners will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. ***Please note, benefit payments may result in a reduction of the maximum coverage available to you under the Plan if CareCheck® is not notified.***

Summary of Utilization Management Programs

HealthPartners utilization management programs help ensure effective, accessible and high quality health care. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of health services. These programs include:

- Inpatient concurrent review and care coordination to support timely care and ensure a safe and timely transition from the hospital
- "Best practice" care guidelines for selected kinds of care
- Outpatient case management to provide care coordination
- The CareCheck® program to coordinate out-of-network hospitalizations and certain services.

We require prior approval for a small number of services and procedures. For a complete list, visit **healthpartners.com** or call Member Services. **You must call CareCheck® at (952) 883-5800 or 1-800-942-4872 to receive maximum benefits when using out-of-network providers for in-patient hospital stays; same-day surgery; new or experimental or reconstructive outpatient technologies or procedures; durable medical equipment or prosthetics costing more than $3,000; home health services after your visits exceed 30; and skilled nursing facility stays. We will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. Benefits will be reduced by 15 percent if CareCheck® is not notified.**

Our Approach to Protecting Personal Information

HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. Our policies and procedures help ensure that the collection, use and disclosure of information comply with the law. When needed, we get consent or authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For a copy of our privacy notice, please visit **healthpartners.com** or call Member Services at (952) 883-5000 or 1-800-883-2177. Please contact your provider for a copy of the HealthPartners privacy notice.

Services Not Covered

After you enroll, you will receive a Group Membership Contract or Summary Plan Description that explain exact coverage terms and conditions. *This plan does not cover all health care expenses*. In general, services not provided or directed by a licensed physician are not covered. The following is a *summary* of excluded or limited items:

- Treatment, services or procedures which are experimental, investigative or are not medically necessary
- Dental care or oral surgery‡
- Non-rehabilitative chiropractic services
- Eyeglasses and contact lenses
- Private-duty nursing; rest, respite and custodial care‡
- Cosmetic surgery‡
- Vocational rehabilitation; recreational or educational therapy
- Sterilization reversal and artificial conception processes‡
- Physical, mental or substance-abuse examinations done for, or ordered by third parties‡

‡ *except as specifically described in your Group Membership Contract or Summary Plan Description.*

THIS PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES.
READ YOUR GROUP MEMBERSHIP CONTRACT OR SUMMARY PLAN DESCRIPTION CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED.
For details about benefits and services, call Member Services at (952) 883-5000 or 1-800-883-2177.

ClearScript – Prescription Drug Benefits

Announcing New Enhancements to your 2013 Pharmacy Benefits Drug Protocol

ClearScript, the pharmacy benefit manager for Duluth Joint Powers Enterprise Trust, uses tools, such as Step Therapy and Prior Authorizations, to help manage and control costs for all health plan members. Below is a brief summary of program enhancements effective January 1, 2013:

Step Therapy Program – New Categories Added

The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. This means that to receive coverage you may need to first try a proven, cost-effective medication before using a more costly treatment, if needed. As always, treatment decisions are ***always*** between you and your doctor.

Beginning January 1, 2013, the Step Therapy program will include 12 additional categories. Please refer to your 2013 Pharmacy Benefit Drug Protocol summary for further details. If you are already taking a medication that is part of the step therapy program, you may not be affected. You may wish to call customer service at 1-800-546-5677 to find out. Members currently stabilized on a second-step drug targeted by the Step Therapy program, may continue the medication without interruption provided the member has:

1) Completed a 30-day trial with a first step drug; or
2) Taken a second-step drug in that category within the last 180 days.

Prior Authorizations – Expanded to Specialty Drugs

Prescription medications are becoming increasingly more expensive and are in greater demand by doctors and patients. New developments in medication therapy have resulted in break-through treatments for complex diseases. These advances have created a relatively new class of prescription medications that is commonly referred to as "specialty drugs." Specialty drugs are complex in both design and administration. They are used to treat conditions such as multiple sclerosis, cancer, HIV and certain forms of rheumatoid arthritis, to name a few. Some of these medications cost as much as $86,000 per year and are costly to ship, store and administer. In order to improve outcomes, and effectively manage costs, specialty drugs will require Prior Authorization beginning in 2013. Members currently taking a specialty drug will be contacted in February regarding the review process. You can view the list of specialty drugs at www.clearscript.org/Duluth/SPECIALTY-PHARMACY-DULUTH.

Voluntary Tablet-Splitting Program

Tablet splitting helps members manage costs by splitting designated double-strength medications in half for each dose. Through this program, members pay up to one-half of their usual co-payment on a select group of prescription drugs including Crestor, Lexapro, and Zoloft. Your health care provider will need to rewrite your prescription. Free tablet splitters are available by contacting the City of Duluth's Human Resources Office.

ClearScript – Prescription Drug Benefits *(continued)*

Medication Therapy Management

Making the Best Use of Your Medication

If you want to be more involved in your medication therapy decisions, a program called Medication Therapy Management (MTM) allows you to do just that, ***and*** it could result in improved health and savings on medication co-pays for you! MTM is set up as a private meeting between you and a specially trained pharmacist. The pharmacist will complete a comprehensive health assessment and reviews all of your medications to be sure they are appropriate, effective and safe. By doing this the MTM pharmacist can identify, resolve, and prevent medication-related problems. **If you are interested in finding out more about the MTM program, please call 1-866-332-3708.**

Eligibility

Medication Therapy Management (MTM) is available to members covered under the Duluth Joint Powers Enterprise Trust's Hospital-Medical Benefit Plan 3A who:

- use four or more program-specified maintenance medications; OR
- have diabetes; OR
- are diagnosed with at least two of the following chronic conditions: high blood pressure, high cholesterol, asthma, chronic pulmonary disease, heart failure, or depression.

Participation

You may participate or continue participating in the MTM program by:

- Choosing an MTM network provider at one of the following locations
  - Cub Pharmacy, 615 W. Central Entrance, Duluth
  - Minneapolis/St. Paul area (for locations, call 612-672-7005 or 1-866-332-3708)

OR

- Enrolling in the new MTM service, Phone Visits, which enable the same service from the convenience of your home.

You will not be charged for MTM appointments. Participating in MTM *does not affect where you get your medications filled.* You may continue to get your prescriptions filled at any of the 64,000 pharmacies in your benefit plan network. Appointments are available weekdays between 7:00 a.m. and 6:30 p.m. You meet privately with a pharmacist at least every three months or as directed by your pharmacist. During the first appointment, the pharmacist will discuss the following with you:

- Medical conditions and medication treatment (e.g. what you know about your medical condition(s), what medication you're taking – including non-prescribed medications, how you take the medications, side effects, etc.)
- Treatment goals and an action plan to meet those goals
- Nutrition and exercise

Prescription Drug Co-Pay Reduction

Not only will you learn how to manage your health conditions better, but you may also qualify to save money by getting selected medicines at a reduced co-payment(s).

Contact Information

Vendor	Contact Information
HealthPartners Medicare Supplement Plan* Customer service representatives are available to answer general and individual specific questions regarding: - Health plan benefits (e.g., general information regarding plan deductible, coinsurance, annual out-of-pocket maximums, lifetime maximums, allowable services, general exclusions, etc.) - Claims (e.g., for an explanation of deductibles or out-of-pocket expenses incurred, claims filing or payment, etc.) - Benefit coordination (e.g., Medicare or other group insurance, subrogation, etc.) - Network providers (e.g., identifying in-network vs. out-of-network providers/clinics/hospitals or chiropractors)	Toll-Free: 1-800-233-9645 (952) 883-7979 TTY Users: 1-800-443-0156 (952) 883-6060
HealthPartners Plan 3A Customer service representatives are available to answer general and individual specific questions regarding: - Health plan benefits (e.g., general information regarding plan deductible, coinsurance, annual out-of-pocket maximums, lifetime maximums, allowable services, general exclusions, etc.) - Claims (e.g., for an explanation of deductibles or out-of-pocket expenses incurred, claims filing or payment, etc.) - Benefit coordination - Network providers (e.g., identifying in-network vs. out-of-network providers/clinics/hospitals or chiropractors)	Toll-Free: 1-800-883-2177 (952) 883-5000 www.healthpartners.com
ClearScript Plan 3A* Customer service representatives are available to answer general and individual specific questions regarding: - Prescription drug plan benefits (e.g., general information regarding plan co-payments and/or coinsurance, preferred drug list, specialty drugs, Medication Therapy Management program (MTM), general exclusions, etc.) - Claims (e.g., for an explanation of charges, claims filing or payment, etc.) - Benefit coordination (e.g., other group insurance) - Network providers (e.g., participating pharmacies)	Customer Service 1-800-546-5677 MTM Phone # 1-866-332-3708 www.clearscript.org
***Please have your group and member identification numbers available to facilitate discussions with the customer service representative.**	

How can I get more information about Open Enrollment?

Open Enrollment Meeting

Representatives from HealthPartners, ClearScript, and CBIZ will present information. Human Resources representatives will also be available to assist with questions or completion of your Benefits Enrollment Form.

Date	Time	Location
Wednesday, November 14th	**12:30 – 2:00 p.m.**	**DECC - Gooseberry Falls Room 3**
***Free Parking will be available*. City Side Convention Center – use Entrance B.** **Stay on the ground floor and follow the posted signs to direct you to the designated location.**		

Contact a Human Resources Representative

Staff in the Human Resources Office are trained to answer your questions and help you with Open Enrollment procedures.

- Human Resources (218) 730-5197, (218) 730-5198, or (218) 730-5204
- Human Resources Retiree Line (218) 730-5888
- Human Resources Email HRinformation@duluthmn.gov

City of Duluth Website - Human Resources Webpage

A variety of information is available at the City of Duluth Human Resources webpage under *Retiree Health Care Information*, www.duluthmn.gov/employment/retiree_health_care

Important Dates and Information

- **November 13 – November 26, 2012:** City of Duluth Retiree Open Enrollment Period
- **November 26, 2012:** Deadline for submitting Benefits Enrollment Form for 2013 Open Enrollment
- **Late-December 2012:** Watch for your new ID card, which will be mailed directly to your home
- **January 1, 2013:** Open Enrollment elections and plan changes take effect
- **Late-January / Early-February 2013:** A Benefit Confirmation Statement will be mailed to your home. Please review for accuracy and report any corrections within 10 business days.

2013 Official Notices

(Open Enrollment Period for 2013 Benefits)

1. **Medicare D Annual Notice**
2. **Federal Health Care Reform Notices**
3. **HIPAA Notice of Privacy Practices**
4. **CHIPRA Annual Notice (Premium Assistance)**
5. **ERRP (Early Retiree Reinsurance Program)**
6. **The Federal Mental Health Parity Act**

THE CITY OF DULUTH MINNESOTA

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see next page for more details.

MEDICARE PART D PRESCRIPTION COVERAGE

IF YOU OR ANY OF YOUR COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, PLEASE DISREGARD THIS NOTICE

However, in determining if you should consider purchasing a Medicare prescription drug plan, you should first look at your medical insurance coverage.

If that coverage is expected to pay out as much or more than the standard Medicare prescription drug program, you will have creditable coverage and will not be penalized if you choose not to enroll in Medicare prescription drug plan at this time and circumstances change and you later want to enroll.

The Duluth Joint Powers Enterprise Trust's Comprehensive Hospital-Medical Benefit Plan 3A is considered creditable, which means they are expected to pay out as much or more than the standard Medicare prescription drug program.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

IF YOU OR ANY OF YOUR COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, PLEASE DISREGARD THIS NOTICE

If you or a covered dependent has Medicare Part A and/or B (or will be eligible within the next 12 months) you will want to read this notice carefully about your current Prescription Drug Coverage and Medicare. **If not, you can disregard this notice.**

NOTE: The Centers for Medicare and Medicaid Services (CMS) regulations require us to provide this notification to all individuals with prescription drug coverage who are eligible for Medicare. You are receiving this letter because we don't know if you, or a covered family member, are entitled to Medicare or not. Medicare entitlement includes individuals who qualify for Medicare because of a disability or end-stage renal disease (ESRD), as well as individuals who are over age 65.

PLEASE READ THIS ENTIRE NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT.

This notice has information about your current prescription drug coverage through the Duluth JPE Trust's Comprehensive Hospital-Medical Benefit Plan 3A and the new prescription drug coverage available January 1, 2006, for people with Medicare. The following health plan options are covered under this notice: **Duluth Joint Powers Enterprise Trust's Comprehensive Hospital-Medical Benefit Plan 3A**. This notice also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. In 2006, Medicare prescription drug coverage became available to everyone with Medicare. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.
2. ClearScript and NPS have determined that the prescription drug coverage offered under the Plan 3A are **creditable**, which means on average for all plan participants, **it is** expected to cover at least as much as the standard Medicare prescription drug coverage (Medicare Part D).
3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. *In addition, if you lose or decide to leave employer sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.* You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE *(continued)*

If you decide to join a Medicare drug plan and continue your Duluth Joint Powers Enterprise Trust's prescription drug coverage, your coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your Duluth Joint Powers Enterprise Trust's prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the City of Duluth and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage…

Contact the City of Duluth Human Resources Office at (218) 730-5198 or (218) 730-5197. NOTE: You may receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You should receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help or to get a copy of the "Medicare & You" handbook;
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number); or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to give a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium amount.

Date:	November 2012
Name of Entity/Sender:	City of Duluth
Contact - Position/Office:	Human Resources
Address:	411 W. First Street, 313 City Hall, Duluth, MN 55802
Phone:	(218) 730-5198 or (218) 730-5197

ORGANIZED HEALTH CARE ARRANGEMENT
NOTICE OF PRIVACY PRACTICES

Effective: January 1, 2011

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

As required by the Health Insurance Portability and Accountability Act, this notice describes the medical information practices of the City of Duluth's Organized Health Care Arrangement (OHCA) and that of any third party that assists in the administration of OHCA Plan claims.

For purposes of HIPAA and this notice, the OHCA includes the following plans:

- Duluth Joint Powers Enterprise Trust Group Health Plan
- Duluth Joint Powers Enterprise Trust Group Dental Plan
- Duluth Joint Powers Enterprise Trust Medical Flexible Spending Account Program
- Duluth Joint Powers Enterprise Trust Employee Assistance Program

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to the applicable medical information maintained by any of the OHCA plans noted above and which is considered protected health information (PHI). Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. If there is a breach of your PHI we shall notify you immediately upon discovery of such breach pursuant to the Health Information Technology for Economic and Clinical Health Act (HITECH).

How We May Use and Disclose Medical Information About You
We may use and disclose any applicable medical information obtained through administration of any of the above noted OHCA plans, for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing you for a medical bill submitted under your medical reimbursement account.
- Health Care Operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
- Required by Law means we will disclose medical information about you when required to do so by federal, state or local law. An example would be when required by a court order or subpoena.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Rights Regarding Medical Information About You
You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to the HIPAA Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. We may charge a fee for the costs of copying and mailing. We also may deny your request in certain very limited situations, and will provide you with an opportunity to request a review of the denial.
- The right to amend your protected health information. We may however, deny your request in certain limited situations.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to notify you of the availability of this notice and you have the right to obtain a written copy of it from us every three years. You may also obtain a copy of this notice at any time from the City's Human Resources website.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Changes to this Notice
We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post the revised notice on the City's Human Resources website and you may also request a written copy of the revised Notice of Privacy Practices.

Complaints
You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our HIPAA Privacy Officer or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

HIPAA Privacy Officer Contact Information:
Steven Hanke, City of Duluth, 411 W. First Street, City Hall, Duluth, MN 55802, (218) 730-5271.

CHIPRA NOTICE

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW (1-877-543-7669)** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list is current as of November 1, 2012. You should contact your State for further information on eligibility

MINNESOTA – Medicaid	**WISCONSIN** – Medicaid
Website: **www.dhs.state.mn.us** *Click on Health Care, then Medical Assistance* Phone (Outside of Twin Cities area): 1-800-657-3739 Phone (Twin Cities area): (651) 431-2670	Website: **www.dhs.wisconsin.gov/medicaid** Phone: 1-800-362-3002

To see if any more States have added a premium assistance program since November 1, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

THE FEDERAL MENTAL HEALTH PARITY ACT

The Federal Mental Health Parity Act was signed into law on Oct. 3, 2008 (the "2008 Act"), as part of the recently enacted economic recovery package (Sections 511 and 512 of HR 1424, PL 110-343). The new law, which amends ERISA, the Internal Revenue Code and the Public Health Service Act, requires insured and self-insured plans to provide "parity" between the financial requirements and treatment limitations applied to: (a.) mental health and substance use disorder benefits; and (b.) medical and/or surgical benefits.

This requirement will take effect for most plans on the first day of their plan year which begins or renews on or after Oct. 3, 2009.

NEW REQUIREMENTS

- The new law does not allow either more restrictive or separate financial requirements for mental health and substance use disorder coverage. It specifically defines the 'financial requirements' that must be in parity as:
    1) Deductibles
    2) Co-payments
    3) Co-insurance
    4) Out-of-pocket expenses
- However, a plan may still have an aggregate lifetime limit and an aggregate annual limit that is applied to both medical and mental health and substance use disorder benefits.
- The law prohibits treatment limits on mental health and substance use disorder benefits that are more restrictive than those of medical/surgical benefits. The law specifically requires the following limitations to be in parity:
    1) Limits on frequency of treatment
    2) Limits on number of visits
    3) Limits on number of days of coverage
    4) Other similar limits on the scope or duration of coverage
- The law requires an explanation of a denial of benefits for mental health and substance use disorder treatment (if requested)
- The law also requires out-of-network (OON) coverage for mental health and substance use disorder treatment if OON coverage is available for medical/surgical benefits
- Employers who have behavioral health benefit limits or cost-sharing requirements will need to review those restrictions against their medical benefits coverage in order to assess whether they meet federal parity requirements of the 2008 Act and, if not, to determine what adjustments need to be made to your plan design to achieve compliance. This review will need to be completed well in advance of the effective date stated above.
- Under the new law, employers can choose which mental health and substance use diagnoses they want to cover. The parity requirements will apply to all diagnoses the employer chooses to cover (subject to applicable state law mandates; many states currently have limits on specific diagnoses such as autism, for example). An employer can not choose to cover some diagnoses at parity and others not at parity.

COMPLAINTS AND QUESTIONS

If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City's Human Resources Office or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.